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prepared by the Bordeaux Working Group *

* F. Dabis (Chief editor) and by alphabetical order: E. Arrivé, R. Becquet, DK. Ekouevi, V. Leroy, D. Marchand, E. Mouillet, J. Orne-Gliemann, F. Perez, C. Sakarovitch.

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Design of the bibliographic retrieval of this issue

Databases: Current Contents Life Sciences, Clinical Medicine, Social & Behavioral Sciences
(weeks # 33 to 39: to August 16, 2004 to September , 2004; coverage: journal and book citations)

Number of citations screened for this issue: 1568

News Groups: AFRO-NETS, AMEDEO, CABA, Kaiser, Medscape, ProCAARE, RHO, UNAIDS e-Workspaces

Number of citations selected for this issue: 6

Subject Headings/Subheadings
Conference summary
Contraception
Gynaecology
Infant feeding/Breastfeeding
MTCT (Mother-to-Child Transmission)
Obstetrics
PMTCT/ARV (Prevention of Mother-to-Child Transmission/AntiRetroVirals)
Primary prevention of sexual transmission/VCT (Voluntary Counselling and Testing)
Termination of pregnancy/Abortion

Citation format (by alphabetical order of the authors)
Author(s). Title. Source.
Abstr. (authors’ abstract) or Notes (prepared by the Bordeaux Working Group)
Author address, if available (for reprints)
Subject Headings

Notes. A cross-sectional survey in Abidjan, Côte d'Ivoire to document the level of understanding of the informed consent document of HIV-1 infected women enrolled in a PMTCT research project.

Address: Project ANRS Ditrame Plus, Programme PACCI, Abidjan, Cote d'Ivoire. ekouevi@aviso.ci

PMTCT/ARV, Infant feeding/Breastfeeding


Abstr. Objective: To compare the safety of nelfinavir and nevirapine-based antiretroviral treatment in HIV-1-infected pregnant women. Methods: In Pediatric AIDS Clinical Trials Group Protocol 1022, 38 antiretroviral-naïve pregnant women at 10-30 weeks' gestation were randomized to nelfinavir or nevirapine with zidovudine plus lamivudine. The study was suspended because of greater than expected toxicity and changes in nevirapine prescribing information. The incidence of treatment-limiting hepatic or cutaneous toxicity was compared between groups for all subjects and for the subset with CD4 cell counts greater than 250 cells/muL at study entry. Results: Toxicity was seen in 1 (5%) of 21 subjects randomized to nelfinavir and 5 (29%) of 17 subjects randomized to nevirapine (P = 0.07). Within the nevirapine group, 1 subject developed fulminant hepatic failure and died, and another developed Stevens-Johnson syndrome. The one adverse event associated with nelfinavir occurred in a subject with a CD4 cell count less than 250 cells/muL. All 5 events among subjects with a CD4 cell count greater than 250 cells/muL were associated with nevirapine (P = 0.04). Conclusions: Continuous nevirapine may be associated with increased toxicity among HIV-1-infected pregnant women with CD4 cell counts greater than 250 cells/muL, as has been observed in nonpregnant women.

Address: Department of Obstetrics/Gynecology University of Washington Medical Center, Box 356460 Seattle, WA 98195. jhitti@u.washington.edu

PMTCT/ARV


Abstr. Objectives: To examine new evidence from studies on the estimates of the fertility rate ratio comparing HIV-infected and uninfected women, of the population change in total fertility attributable to HIV, and to review the evidence of changes in fertility in HIV-uninfected women. Design: A review and analysis of data from the many individual studies that have examined the associations between HIV/AIDS and fertility. Methods: Data from sub-Saharan Africa were collected from published studies, personal communications and the Demographic and Health Surveys. A mathematical model was used to demonstrate the impact of the HIV/AIDS epidemic on the number of births in Uganda. Results: Fertility was lower among HIV-infected women than HIV-uninfected women, with the exception of those aged 15-19 years, in whom the selective pressure of sexual debut on pregnancy and HIV infection led to higher fertility rates among the HIV infected. This fertility differential resulted in a population-attributable decline in total fertility of 0.37% (95% confidence interval 0.30%, 0.44%) for each percentage point of HIV prevalence. The evidence for fertility changes in HIV-uninfected women was ambiguous. An estimated reduction of 700 000 births occurred in Uganda, as a result of the reduced fertility in HIV-infected women and premature mortality among reproductive age women. Conclusion: Large fertility differentials existed between HIV-infected and uninfected women, with substantial variation by age. The extent to which these could be attributed to the direct impact of the epidemic on both infected and uninfected women, as opposed to pre-existing differences in their fertility, merits further study. (C) 2004 Lippincott Williams Wilkins.

Address: Department of Infectious Disease Epidemiology, Imperial College Faculty of Medicine, University of London, Norfolk Place, W2 1PG, UK.

Contraception, Obstetrics


Abstr. Objective: Assess the impact of AIDS on prevalence of orphanhood and care patterns. Methods: Descriptive analysis of nationally representative household surveys from 40 countries in sub-Saharan Africa. Results: Overall 9% of children under 15 years have lost at least one parent in sub-Saharan Africa. On average one in six households with children are caring for orphans. Orphans more frequently live in households that are female-headed, larger, and have a less favourable dependency ratio. The head of the household is considerably older. Child caring practices differ
between countries, and between non-orphans and orphans. Based on the country medians, almost nine out of 10 non-orphans live with their mother and eight out of 10 non-orphans live with their father. Single orphans are less likely to live with their surviving parent: three out of four paternal orphans live with their mother and just over half of maternal orphans live with their father. The (extended) family takes care of over 90% of the double orphans. Orphans are approximately 13% less likely to attend school than non-orphans. Double orphans are most likely to be disadvantaged. Conclusion: The epidemic has caused rapid recent increases in the prevalence of orphanhood. Prevailing childcare patterns have dealt with large numbers of orphans in the past, and to date there is no consistent evidence that this system is not absorbing the increase in orphans on a large scale.Yet, there is some evidence that orphans as a group are especially vulnerable, as they live in households with less favourable demographic characteristics and have lower school attendance. (C) 2004 Lippincott Williams Wilkins.

**Address:** United Nations Children's Fund, New York, NY 10017, USA. rmonasch@unicef.org


**Abstr.** Objectives: To review the available data relating to child mortality in Africa by the HIV infection status of mothers and children. Results: Child survival is influenced by the HIV epidemic through several mechanisms. Mother-to-child transmission of HIV ranges from 15 to 45%, with up to 15-20% resulting from breastfeeding. HIV-infected children have high mortality rates. For example, a recent community-based study in Rakai, Uganda, showed 2-year mortality rates of 547, 166 and 128 per thousand among HIV-infected children, HIV-negative children of HIV-positive mothers, and HIV-negative children of HIV-negative women, respectively. Child mortality estimates from community-based cohorts demonstrate that the children of HIV-infected mothers have higher mortality rates than the children of uninfected mothers, and that child mortality is closely linked with maternal health status, but because the proportion of vertically infected children is unknown, the value of these studies is limited. Models that use HIV surveillance data together with a set of assumptions indicate that child mortality caused by HIV/AIDS has increased throughout the 1990s to reach close to 10% by 2002. Conclusion: Both disparate trends in HIV prevalence and varying levels of non-HIV-associated child mortality will ensure very different impacts in different countries. To improve the projections of the overall effect that the HIV epidemic will have on child mortality at the population level in countries with generalized epidemics, reliable age-specific mortality rates in infected and uninfected children are needed. (C) 2004 Lippincott Williams Wilkins.

**Address:** Centre for Paediatric Epidemiology and Biostatistics, Institute of Child Health, University College London, UK. m.newell@ich.ucl.ac.uk


**Abstr.** Objectives. We investigated how, under various conditions, the risk of mother-to-child transmission of HIV through breastfeeding compares with the risk of death from artificial feeding. Methods. We developed a spreadsheet simulation model to predict HIV-free survival during 7 age intervals from 0 to 24 months for 5 different infant feeding scenarios in resource-poor settings. Results. Compared with artificial feeding, breastfeeding during the first 6 months by HIV-positive mothers increases HIV-free survival by 32 per 1000 live births. After 6 months, as the age-specific mortality rate and risk of death caused by replacement feeding both decline, replacement feeding appears to be safer. Conclusions. Under conditions common in countries with high HIV prevalence, replacement feeding by HIV-infected mothers should not be generally encouraged until after the infant is approximately 6 months old. **Address:** Academy for Educational Development, Washington, DC, USA. jayross@aed.org

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